LONG TERM CARE WAIVER PROGRAM
NOTICE OF ACTION

Client's Name _____ State ID#/Medicaid #_____
Address _____ Date of Birth _____

THIS NOTICE REFERS TO THE FOLLOWING LONG TERM CARE PROGRAM(S)

___Children's Extensive Support (HCBS-CES)
___Children's Habilitation Residential Program (HCBS-CHRP)
___Children's Home and Community Based Services (CHCBS)
___Home and Community Based Services for Brain Injured (HCBS-BI)
___Home and Community Based Services for Children with Autism (HCBS-CWA)
___Home and Community Based Services for Mental Illness (HCBS-MI)
___Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA)
___Home and Community Based Services for the Developmentally Disabled (HCBS-DD)
___Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD)
___Supported Living Services (HCBS-SLS)
___Adult Foster Care (AFC) ___Home Care Allowance (HCA)
___Long Term Home Health (LTHH)
___Program of All-Inclusive Care for the Elderly (PACE)
___Nursing Facility
___Consumer Directed Attendant Support (CDAS)
___Consumer Directed Care for the Elderly (CDCE)
___Other _____

(A) _____You have been determined to be functionally eligible for the above program as of _____. You will not begin to receive services unless and until your Medicaid application has been processed and approved by the Income Maintenance Technician in your county of residence.

(B) _____You have been determined to meet the long-term care eligibility for the program checked above and are being placed on the waiting list effective _____.

(C) ____ Services are being decreased or changed effective _____ because _____
_____
Services being decreased or changed are _____
Rule(s) which apply: (Cite specific rule number) _____

(D) ____You are NOT eligible for placement on the waiting list or NOT eligible or no longer eligible to receive service(s) through the above program(s) effective _____ because:

_____You do not meet the functional eligibility level.
_____You do not meet the targeting criteria for the program.
_____You did not agree to receive services or have not received services for thirty (30) days.
_____You have refused two times in a thirty (30) day consecutive period to schedule an appointment for assessment or failed to keep three scheduled assessment appointments within a thirty consecutive day period.
_____You cannot be safely served under the cost limits of the HCBS program.
_____You are hospitalized for thirty (30) days.
_____You do not meet the function impairment threshold score for the HCA Program.
_____You do not have an unmet need for paid care from the HCA Program.
_____You do not meet the Appropriateness of Placement criteria for the AFC or ACF Programs.
_____You refused to sign the Intake, Care Plan and/or Release of Information forms or other forms as required to receive services.
_____Other: _____

Rule(s) which apply: (Cite specific rule number) _____

If you disagree with the proposed action described above, you may <u>appeal</u> to the state and have a hearing with a State Administrative Law Judge. To continue your current services you must file an appeal by the effective date above. You should be aware that the State of Colorado and designated case management agency may attempt collection or seek to collect repayment from you for all benefits you received if you lose the appeal.

You must <u>file</u> your written request for a hearing with:

THE STATE OFFICE OF ADMINISTRATIVE COURTS, 1525 SHERMAN STREET, 4TH FLOOR, DENVER, CO 80203 BY _____ OR YOU MAY LOSE YOUR APPEAL RIGHTS.
Date

_____	_____	_____	_____
Case Manager's Signature	Phone Number	Supervisor's Signature	Phone Number
_____		_____	_____
Case Management Agency		Mailed by	Date

THE FIRST PAGE OF THIS FORM GIVES YOU NOTICE OF A PROPOSED ACTION BY THE CASE MANAGEMENT AGENCY. THE FOLLOWING IS AN EXPLANATION OF YOUR APPEAL RIGHTS.

STATE APPEAL

If you disagree with the proposed action listed on the first page of this form and choose to appeal to the State, you must **write** to **the State Office of Administrative Courts at 1525 Sherman Street, 4th Floor, Denver, CO 80203. Your written request must be received by the Office of Administrative Courts by the date specified on the Notice of Action form.**

State in the letter that you want to appeal and why. You may obtain assistance from anyone including a legal aid office to complete the necessary paperwork.

When your appeal is received, the Office of Administrative Courts will send you a letter explaining the time, place and procedure for the appeal hearing. You have the right to represent yourself or have an attorney, friend, relative or other spokesperson represent you at the hearing.

The case management agency is required to give you full and complete explanation of the proposed actions. You or your authorized representative have the right to examine the documents that were considered by the case management agency in determining this proposed action.

DISCRIMINATION

If you believe that you have been discriminated against because of race, color, sex, age, religion, political beliefs, national origin, or disability you have the right to file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202.

STATEMENT OF PENALTIES

If you make a willfully false statement or representation, or use other fraudulent methods to obtain public assistance or medical assistance you are not entitled to, you could be prosecuted for theft under state and/or federal law. If you are convicted by a court of fraudulently obtaining such assistance, you could be subject to a fine and/or imprisonment for theft.

REQUEST FOR ADMINISTRATIVE LAW JUDGE HEARING

I disagree with the case management agency's decision that I am not functionally eligible to receive long term care waiver services based on the reason entered on the attached Notice of Action form. I wish to have my case reconsidered by an Administrative Law Judge.

Please list your reason(s) for appealing here:

_____

_____

_____

_____

_____

_____ _____ _____

Date Printed Name of Client Social Security #

_____ _____

Signature of Client State ID Number

_____

Address

_____ _____ _____

City and State Zip Code Area Code & Phone

_____ _____ _____

Representative (if applicable) Area Code & Phone

_____

Printed Name of Case Management Agency

This written request must be received by the Office of Administrative Courts by _____.
Date

Mail this completed form to: State Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203